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No. 90-328

In the Supreme Court of the United States

OCTOBER TERM, 1990

BODIMETRIC HEALTH SERVICES, INC., ET AL., PETITIONER

v.

AETNA LIFE AND CASUALTY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Petitioner Bodimetric Health Services, a provider of services under Part A of the Medicare Program, brought this suit against a fiscal intermediary designated by the Secretary of Health and Human Services to administer the Medicare claims-adjudication process on his behalf. Petitioners allege that the intermediary incorrectly denied a large number of those claims, and they seek to recover from the intermediary, under a variety of state-law theories, the amount of benefits that allegedly should have been paid on those claims, plus consequential damages.

The question presented is:

Whether petitioners' suit is barred by 42 U.S.C. 1395ff, which prescribes the exclusive procedures for obtaining judicial review of administrative decisions denying medicare claims, or by 42 U.S.C. 405(h), which (i) provides that no findings of fact or decision of the Secretary shall be reviewed by any tribunal except as provided in the Social Security Act, and (ii) bars other forms of judicial actions on claims arising under the Act.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-21a) is reported at 903 F.2d 480. The opinion of the district court (Pet. App. 22a-36a) is reported at 706 F. Supp. 619.

JURISDICTION

The judgment of the court of appeals was entered on May 25, 1990, and the petition for a writ of certiorari was filed on August 21, 1990. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Petitioner Bodimetric Health Services, Inc., owned and operated 15 home health agencies (HHAs) that provided in-home medical services as an alternative to institu-

tional treatment.[1] Bodimetric's HHAs were certified as providers of services under the Part A Medicare Program, 42 U.S.C. 1395c *et seq.*, which establishes a federal program of insurance for the reasonable cost of hospital and related post-hospital services. 42 U.S.C. 1395c, 1395d, 1395f(b). In order for home health care services to be covered by Medicare, a physician must certify that they are necessary, that the beneficiary is confined to a home, and that a plan of treatment has been developed. 42 U.S.C. 1395f(a)(2)(C). Pet. App. 2a-3a.

The Act provides that the determination of the amount of benefits payable under Part A for particular services "shall be made by the Secretary in accordance with regulations prescribed by him." 42 U.S.C. 1395ff(a). The Secretary has entered into agreements with intermediaries under which the latter determine the amount of benefits and make the payments to HHAs. 42 U.S.C. 1395h. As confirmed by the legislative history of the Medicare Act, an intermediary acts as the agent of the Secretary in administering the program (S. Rep. No. 404, 89th Cong., 1st Sess. 54 (1965)):

> In the performance of their contractual undertakings, the carriers and fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard

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[1] The two other petitioners are Bodimetric's parent corporation, American Service Bureau, and its affiliate, Bodimetric Home Health Care, Inc. Pet. App. 22a. Only petitioner Bodimetric operated the HHAs involved in this case. The other petitioners allegedly suffered consequential losses as a result of respondent's denial of claims filed on behalf of patients of Bodimetric's HHAs.

> the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary.

As this Court recognized in *United States* v. *Erika, Inc.*, 456 U.S. 201, 206 n.4 (1982), a regulation promulgated by the Secretary makes the same point, and accordingly provides that the Secretary is the real party in interest in any dispute concerning administration of the Medicare Program. 42 C.F.R. 421.5(b).[2]

If a fiscal intermediary determines that particular services furnished by an HHA or other provider were not reasonable and necessary, were for custodial care, or are otherwise not covered by Medicare, the beneficiary or (in some circumstances) the provider may request reconsideration by the intermediary. 42 C.F.R. 405.710, 405.711. If the intermediary's reconsideration decision again denies the claim and the amount in controversy exceeds $100, the beneficiary or provider may request a hearing before an administrative law judge in HHS. See 42 U.S.C. 1395ff(b)(1); 42 C.F.R. 405.724.[3] If the claim is again

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[2] 42 C.F.R. 421.5(b) provides:

> Intermediaries and carriers act on behalf of the Administrator [of the Health Care Financing Administration] in carrying out certain administrative responsibilities that the law imposes. Accordingly, their agreements and contracts contain clauses for indemnification with respect to actions taken on behalf of the Administrator, and the Administrator is the real party in interest in any litigation involving the administration of the program.

[3] Prior to July 1, 1987, an ALJ hearing was available on the question whether services were reasonable and necessary and not custodial in nature. In 1987, Congress amended 42 U.S.C. 1395ff(b)(1) by adding a new paragraph (D) clarifying that an ALJ hearing is available on other issues as well. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 2002-2003.

denied, any party to the hearing may seek judicial review, as provided in 42 U.S.C. 405(g), if the amount in controversy exceeds $1000. 42 U.S.C. 1395ff(b)(2). See *Heckler* v. *Ringer,* 466 U.S. 602, 606-607 (1984); Pet. App. 5a.[4]

2. Respondent Aetna Casualty & Surety is the intermediary designated by the Secretary to adjudicate claims submitted on behalf of the Medicare beneficiaries who received services from Bodimetric's HHAs. Petitioners allege in this case that, beginning in 1985, Aetna unlawfully denied a substantial number of claims submitted by Bodimetric. Petitioners further allege that these denials were prompted by an HHS contractor evaluation released in early 1985 that was critical of Aetna's performance as an intermediary and that caused Aetna to adopt a more restrictive approach in reviewing claims. In petitioners' view, Aetna sought to raise its denial rate, and thereby improve its performance evaluation under HHS standards, in order to retain its contract with the Secretary as a fiscal intermediary. Pet. App. 3a-4a. Petitioners allege that Aetna's denials of claims injured them by, *inter alia,* depriving them of the funds Bodimetrics would have received in payment of the claims, requiring them to devote undue resources to the presentation of claims, and ultimately causing Bodimetric to go out of business. In this suit, in which jurisdiction rests on diversity of citizenship under 28 U.S.C. 1332, petitioners seek to recover

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[4] The procedures described in the text for resolution of coverage and payment disputes concerning services rendered to individual beneficiaries is distinct from the procedures under 42 U.S.C. 1395*oo* for determining the total reimbursement to which the provider is entitled for all covered services during the year, based on the provider's cost report. See *Bethesda Hospital Ass'n* v. *Bowen,* 485 U.S. 399 (1988).

more than $8 million in damages from Aetna under a variety of state-law tort and contract theories. Pet. App. 4a.[5]

The United States moved to intervene and, together with Aetna, moved to dismiss the complaint on jurisdictional and official immunity grounds. On the immunity issue, the United States and Aetna relied on the fact that a fiscal intermediary acts on behalf of the Secretary in determining the amount of benefits and making payments under Medicare. Although the district court rejected the immunity defense, Pet. App. 32a-33a, it granted Aetna's motion to dismiss. The court concluded that petitioners' action is inextricably intertwined with claims for Medicare benefits, and that the statutory mechanisms for administrative and judicial review of an intermediary decision denying a claim furnish the exclusive remedies in circumstances such as these. Pet. App. 34a-36a.[6]

3. The court of appeals affirmed. Pet. App. 1a-21a. It held that petitioners' claims are barred by both the exclusive judicial-review provisions in 42 U.S.C. 1395ff and by the jurisdictional preclusion in 42 U.S.C. 405(h) (as made applicable to the Medicare Program by 42 U.S.C. 1395ii) of other suits "arising under" the Medicare Act.

The court first noted that under *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), the carefully drawn provisions in 42 U.S.C. 1395ff(b) for judicial review of decisions concerning the "amount of benefits" to which a beneficiary is entitled under Part A preclude any other avenue of judicial

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[5] Petitioners also alleged civil violations of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1964(c), but they have since withdrawn their RICO claims. Pet. 8 n.6.

[6] The district court also concluded that the United States motion to intervene was rendered moot by the dismissal of the suit. Pet. App. 23a.

review of a decision denying a claim for benefits.[7] Because the court concluded that petitioners' suit at bottom challenges the amount of benefits Aetna found to be payable for particular services, it held that petitioners' suit is barred by Section 1395ff. The court distinguished *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which held that the Medicare Act does not bar challenges to regulations issued by the Secretary, on the ground that petitioners here challenge the actions of Aetna, not any regulations of the Secretary. Pet. App. 10a-12a. It also noted that unlike in *Michigan Academy*, where 42 U.S.C. 1395ff did not then provide for judicial review of the Part B claims that were adjudicated by carriers under the challenged regulation, judicial review *is* available under Section 1395ff with respect to the amount of benefits payable on Part A claims. Pet. App. 12a-13a.

Finally, the court of appeals held that this suit is also barred by 42 U.S.C. 405(h), which precludes avenues of judicial review other than those specified in the Social Security Act itself. In particular, the court reasoned that Section 405(h) bars a federal court from entertaining state-law challenges to the administrative denial of Medicare claims under its diversity jurisdiction (28 U.S.C. 1332), just as Section 405(h) has been held to bar judicial challenges to administrative decisions denying benefits by resort to federal-question jurisdiction under 28 U.S.C. 1331. Pet. App. 14a-20a.[8]

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[7] Section 1395ff(b) expressly provides that a determination of the amount of benefits for these purposes "includ[es] a determination where such amount is determined to be zero." Hence, Section 1395ff(b) provides for review of decisions that deny a benefit claim in its entirety.

[8] Because the court of appeals affirmed the district court's dismissal of the complaint, it did not decide whether the district court erred in

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of any other court of appeals. Accordingly, further review is not warranted.

1. Two different Sections of the Social Security Act independently preclude this suit: 42 U.S.C. 1395ff and 42 U.S.C. 405(h). Those provisions ensure that challenges to the decisions of the Secretary (or of intermediaries and carriers acting on his behalf) on the millions of claims filed annually under the Social Security Act are channeled through the statutory provisions for administrative and judicial review that Congress has specifically and carefully prescribed in the Social Security Act itself. See 1395ff(b), incorporating 42 U.S.C. 405(b) and (g). Even challenges based on the Constitution or other federal statutes must be presented through these special statutory review procedures, rather than in an independent suit. See *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975); *Mathews* v. *Eldridge*, 424 U.S. 319, 327 (1976); *Heckler* v. *Ringer*, 466 U.S. at 614-616, 622; see also *Schweiker* v. *Chilicky*, 487 U.S. 412, 424 (1988). In view of this comprehensive scheme, the Court declined in *Chilicky* to permit *Bivens* actions[9] against the Secretary and subordinate federal and state officials who act as his agents in administering another program under the Social Security Act (the disability

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denying the United States' motion to intervene. Pet. App. 20a n.10. In our view, the district court did err on this point, since the federal government is the real party in interest in a suit arising under the Medicare Program.

[9] *Bivens* v. *Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971).

program) to recover damages for alleged violations of the Constitution.

The net effect of the relevant statutory provisions and this Court's decisions construing them is to permit administrative decisions denying claims for Medicare benefits and other Social Security benefits to be challenged only on *direct review* under the procedures prescribed in the Act itself for that purpose, and to foreclose a *collateral attack* on those decisions in a separate lawsuit against the Secretary or his agents, in either their official or their personal capacities.

The court of appeals' holding in this case respects this arrangement: it prevents beneficiaries and other participants in the vast Social Security programs from circumventing the special statutory review procedures, and mounting a collateral attack on administrative decisions denying their claims for benefits, simply by recasting their attack as one based on state common law of tort or contract. In fact, this result would seem to follow *a fortiori,* because there is no reason to believe that Congress would have intended to permit adjudicatory decisions made by persons responsible for administering a federal program that is pervasively regulated by federal statutory law to form the basis for personal liability under the varying common law of the States.[10]

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[10] This case involves challenges to decisions made on behalf of the Secretary in the course of administering the Medicare Act, which necessarily "arise under" that Act for purposes of the preclusions of review in 42 U.S.C. 405(h) and 1395ff. We do not suggest that those provisions would bar a suit based on an ordinary common law tort committed by an intermediary or its employee that did not arise under the Act in this sense—*e.g.*, a suit based on an assault or battery committed against a Medicare beneficiary who came into the intermediary's offices to discuss a claim. In that situation, of course,

2. Contrary to petitioners' contention (Pet. 16-20), the decision of the court of appeals to that effect is entirely consistent with this Court's decisions in *Erika* and *Michigan Academy*. As the court of appeals recognized, Pet. App. 8a, *Erika* held that in view of the "precisely drawn provisions" of 42 U.S.C. 1395ff, which provided for judicial review of the amount of benefits payable on a claim under Part A of the Medicare Act but not (at that time) under Part B, judicial review of a carrier's decision concerning the amount of benefits under Part B is foreclosed. See 456 U.S. at 208. As the court of appeals further recognized, Pet. App. 9a, *Michigan Academy* held that Section 1395ff (and 42 U.S.C. 405(h)) did not bar an action under the Administrative Procedure Act, 5 U.S.C. 701, to challenge regulations of the Secretary that bind carriers in making their decisions on claims for benefits, especially since the foreclosure of judicial review of individual carrier decisions would leave open no other avenue for such a challenge. 476 U.S. at 675-676, 678, 679-681.

The court below reconciled *Erika* and *Michigan Academy* as follows (Pet. App. 9a):

> Thus, the Court in *Erika* and *Michigan Academy* recognized the differences between two types of Medicare claims: challenges to the amount of benefits to be paid are not reviewable, while challenges to the regulatory scheme under which the amount of benefits is calculated are reviewable.

This interpretation of *Erika* and *Michigan Academy* is correct and is consistent with decisions of other courts of appeals. See *Texas Medical Ass'n* v. *Sullivan*, 875 F.2d

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the special review procedures whose integrity the statutory preclusions of review are designed to protect are inapplicable.

1160 (5th Cir.), cert. denied, 110 S. Ct. 573 (1989); *Kuritzky* v. *Blue Shield of Western New York,* 850 F.2d 126 (2d Cir. 1988), cert. denied, 488 U.S. 1006 (1989), *McCuin* v. *Secretary of HHS,* 817 F.2d 161, 164-166 (1st Cir. 1987); *Linoz* v. *Heckler,* 800 F.2d 871, 876 (9th Cir. 1986).

In this case, petitioners challenge conduct by Aetna, allegedly in violation of the Medicare Act and implementing regulations and standards (as well as state law), which in turn led Aetna to deny claims for benefits. Petitioners do not challenge any regulations or directives of the Secretary. This case therefore cannot proceed under the rationale of *Michigan Academy.*

Moreover, as the court of appeals pointed out, Pet. App. 12a, here, unlike in *Michigan Academy,* Section 1395ff *does* provide for administrative review by the Secretary of an intermediary's decision denying a Part A claim; and Section 1395ff *does* provide for judicial review of such a claim pursuant to 42 U.S.C. 405(g), which expressly allows challenges to any regulation on which the Secretary's final decision denying the claim is based. As a result, even a challenge to a Part A regulation may be raised only in an action for judicial review of the Secretary's final decision denying benefits, pursuant to 42 U.S.C. 1395ff and 405(g), not in an independent action. See 5 U.S.C. 703 (the form of proceeding for judicial review of agency action "is the special statutory review proceeding relevant to the subject matter").[11] In any event, *Michigan Academy* was based in large measure on the presumption, embodied in the APA, in favor of judicial review of agency action

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[11] Since *Michigan Academy* was decided, Congress has amended 42 U.S.C. 1395ff(b)(1)(C) and (2)(B) to provide for judicial review of the amount of benefits under Part B as well, where the amount in controversy is at least $1000. Under the current statutory scheme, then, even challenges to Part B regulations of the sort involved in *Michigan Academy* should be presented in the statutory review procedure.

under federal law, in order to assure that agency action conforms to standards imposed by the Constitution and Acts of Congress. 476 U.S. at 670-673, 680-681. *Michigan Academy* is therefore of little assistance to petitioners in their quite different argument in favor of allowing agency action to give rise to state-law damage suits.

Petitioners nevertheless argue (Pet. 12, 13, 19, 21-22) that the preclusion of review under Section 1395ff and *Erika* should not apply to damage actions resting on state-law theories of recovery. Even under the most generous standard for allowing a state-law damage action, however, petitioners clearly could not recover damages for injuries allegedly sustained as a result of Aetna's decisions concerning the amount of benefits due for services rendered by Bodimetric's HHAs without at least proving that those decisions were erroneous under the Medicare Act and implementing regulations. If those administrative decisions on behalf of the Secretary were *correct* as a matter of federal law, they could not, under settled preemption principles, give rise to damage liability under state law. See *Kalo Brick & Tile Co.* v. *Chicago & N.W. Transp. Co.*, 450 U.S. 311 (1981). It follows, therefore, that a necessary element of petitioners' cause of action is a showing that Aetna's decisions concerning the amount of benefits due on the claims at issue were *incorrect* under the Medicare Act. For this reason, this suit plainly does involve the "amount of benefits" payable under the Medicare Act, and is foreclosed by 42 U.S.C. 1395ff and *Erika*.

The court of appeals reached the same conclusion, observing that "Bodimetric's grievance is, at bottom, a challenge to Aetna's approach to processing claims." Pet. App. 11a. It elaborated in rejecting petitioners' reliance on *Michigan Academy* (Pet. App. 13a-14a (citations omitted)):

> [Petitioners'] reading of *Michigan Academy* is too broad. A party cannot avoid the Medicare Act's juris-

tional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits. If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined. As a result, Bodimetric's claim is not governed by *Michigan Academy*; instead, it is governed by the terms of *Erika*. It therefore is subject to the exclusive review provisions of section 1395ff.

3.a. This conclusion is strongly reinforced by 42 U.S.C. 405(h), which independently bars this suit. The second sentence of Section 405(h) states that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal,* or governmental agency except as herein provided" (emphasis added). Petitioners' suit is barred by this provision, because it necessarily asks the federal "tribunal" to "review[]" the decisions made by Aetna on behalf of the Secretary (*i.e.*, the "decision[s] of the Secretary") concerning the amount of benefits payable on the claims at issue; under the Social Security Act, such a state-law damage action is not the method "herein provided" for judicial review.[12]

The third sentence of Section 405(h) yields the same result. As the court of appeals pointed out, when Section 405(h) was originally enacted, it provided that "[n]o action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title

[12] The Court observed in *Michigan Academy* that the purpose of the first and second sentences of Section 405(h) is to require exhaustion of administrative remedies. 476 U.S. at 679 n.8. Although the second sentence serves that function, by its terms it bars all review of any decision by *any* "tribunal," except as provided in the Act itself.

28 to recover on any claim arising under this title." Pet. App. 17a; see 42 U.S.C. 405(h) (1964 ed.).[13] At that time, Section 41 of Title 28 "contained all of that title's grants of jurisdiction to the United States district courts," except for several special purpose grants that are of no relevance here. *Salfi*, 422 U.S. at 756 n.3. Section 405(h) therefore barred suits brought under the grant of diversity jurisdiction now contained in 28 U.S.C. 1332. In the Deficit Reduction Act of 1984, the third sentence of Section 405(h) was amended to substitute "section 1331 or 1346 of title 28" for "section 41 of title 28." Pub. L. No. 98-369, § 2633(a)(4)(D), 98 Stat. 1162. However, Section 2664(b) of the same Act, 98 Stat. 1171-1172, provides that none of the amendments in Section 2663 "shall be construed as changing or affecting any right, liability, status, or interpretation which existed * * * before [its effective] date." Accordingly, as the court of appeals concluded, Section 405(h) continues to have the same preclusive effect as before, and thus a suit based on a district court's diversity jurisdiction is barred. See Pet. App. 19a-20a. Petitioners do not challenge this interpretation by the court of appeals, and it does not in any event warrant review.

b. According to petitioners (Pet. 7-8), they did not appeal many of the decisions by Aetna denying particular claims for benefits. Under principles of administrative finality and res judicata, as well as the preclusion-of-review principles just discussed, those decisions must be regarded as correct for present purposes, and they cannot in any event give rise to a state-law damage action. In some instances, petitioners did pursue administrative appeal rights

[13] The court of appeals correctly determined that, in light of an intermediary's important role in administering the Medicare Program on behalf of the Secretary, Section 405(h)'s preclusion of suits against the United States, the Secretary, or an officer or employee thereof, cannot be circumvented by suing an intermediary. Pet. App. 14a-16a.

and obtained a decision by an ALJ that reversed Aetna's decision and awarded benefits. But petitioners cannot premise a damage action on that subset of claims either. When the beneficiaries or petitioners were awarded benefits by an ALJ after such a ruling, they received all of the relief Congress believed was necessary to remedy an erroneous decision at an earlier stage in the administrative review process. *Mathews* v. *Eldridge*, 424 U.S. at 339.

Because Congress chose not to permit recovery of consequential damages as well, see *Chilicky*, 487 U.S. at 426, petitioners complain (Pet. 12) that confining them to the statutory remedies provided by Congress will "leave serious injuries uncompensated." But the statutory remedies under 42 U.S.C. 1395ff, which incorporate those under Section 405, reflect a careful balancing of competing private and governmental interests, and, as this Court recognized in *Erika*, the legislative history of Section 1395ff shows that "the remedies provided by these review procedures shall be exclusive." 456 U.S. at 209 n.11 (quoting S. Rep. No. 404, *supra*, at 54-55). The courts may not strike a different balance by allowing a recovery beyond the monetary remedies that Congress has permitted. *Chilicky*, 487 U.S. at 427-429; *Ringer*, 466 U.S. at 625.

4. Contrary to petitioners' contention (Pet. 12-16), the decision below does not conflict with the decision of the Eighth Circuit in *Rochester Methodist Hospital* v. *Travelers Insurance Co.*, 728 F.2d 1006 (1984). In that case, the court of appeals held, *inter alia*, that sovereign immunity did not bar a tort suit by a Medicare provider against a fiscal intermediary and that the United States was not an indispensable party to such an action. *Id.* at 1012-1017. It did not, however, address the legal question decided by the court of appeals here (and the subject of the conflict that petitioners allege): whether the review mechanisms set forth at 42 U.S.C. 1395ff and 42 U.S.C. 405 are

exclusive and therefore bar actions such as petitioners'.[14] Indeed, petitioners concede (Pet. 15) that the "*Rochester* opinion expressly addresses only timeliness of appeal and sovereign immunity as possible bars to judicial review," and that the purported conflict warranting review by this Court arises from "unstated points" in the *Rochester* opinion that comprise a "*sub silentio* ruling."[15] When a court resolves a case on the merits without actually ruling on a jurisdictional issue that may be present in the case, its decision does not constitute binding precedent on the jurisdictional issue. *Hagans* v. *Lavine,* 415 U.S. 528, 535 n.5 (1974).

5. Petitioners are dissatisfied with the remedies Congress has provided for disputes over Medicare reimbursement matters (payment of the amount of benefits due), and they brought this action for other relief not recoverable under the Medicare Act by casting the action as a dispute between private parties that is wholly unrelated to standards for Medicare reimbursement. But in its role as a Medicare fiscal intermediary, Aetna performed every act complained of in the course of serving as the Secretary's

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[14] Our review of the briefs filed with the court of appeals in *Rochester Methodist Hospital* confirms that neither the government nor the provider raised this issue in the course of the appeal.

[15] The entire basis for petitioners' submission on this point (see Pet. 15) is a brief discussion in a footnote in the *Rochester* opinion of the proceedings in the district court in that case, in which the district court held that federal-question jurisdiction was barred by Section 405(h), dismissed the case because of the absence of complete diversity, and then reinstated the case when diversity was established. See 728 F.2d at 1010 n.6. There is no indication that the question of the effect of Section 405(h) on diversity jurisdiction was even raised in the district court. It therefore is not surprising that, as the court below observed (Pet. App. 18a), the *Rochester* court failed to discuss the revision of 42 U.S.C. 405(h) or the legislative history accompanying it.

agent for administering the Medicare program. Underlying all of petitioners' grievances are Aetna's actions on the Secretary's behalf on claims that the petitioners submitted.

Virtually any disappointed Medicare or other Social Security claimant could recast his challenge to an administrative decision denying his claim for benefits into a challenge to conduct underlying that decision—and then seek damages for the underlying conduct. Allowance of state-law damage actions in these circumstances would therefore invite widespread disruption of the Medicare Program and other Social Security programs, divert scarce resources to such litigation, and result in monetary remedies beyond those Congress intended. Such a ruling would give rise either to a substantial drain on the Medicare Trust Fund to pay such judgments against intermediaries or (if the United States did not make the intermediaries whole) to a substantial disincentive for organizations to take on the task of serving as intermediaries.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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